MyCom MyPATH
Medical Release Form

In order to participate in the MyPATH program all members are required to complete this form and submit it signed by a parent/guardian along with their application.

Please Type or Print Information:

Child's Name_____ Parent/Guardian Name_____

School Name_____ Birth Date_____

Home Address_____ Apt/Suite #_____

City, State, Zip _____

Phone Number _____ Alternate Number_____

Physician Name_____ **Physician Office Phone**_____

Office Address_____

Emergency Medical Contact_____

Phone Number_____ **Alternate Number**_____

Please Completely Describe Any Medical Condition, which may recur or be a factor in medical treatment,

(i.e., Allergies(including medication),Seizure Disorder,Blackouts,Heart or Lung Problems, Disease, Physical Limitations, or a Condition Currently Being Treated)

_____

_____

_____

Please list all medication you are currently taking:

_____

Please Check One of the Following:

___ I give permission for immediate medical treatment as required in the judgment of the attending physician. Notify me and/or any persons listed above as soon as possible.

___ I do not give permission for medical treatment until I have been contacted

Liability Release: I certify that the information above is accurate and complete to the best of my knowledge. I understand that each individual is responsible for his/her own insurance coverage. I hereby release Partnership for a Safer Cleveland, all MyCOM related affiliates, and any designated individual in charge of the specific activity from any legal or financial responsibility.

Child's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____